Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HERMAN HOSPITAL

Respondent Name
BRITISH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-98-8595-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 3, 1997

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position statement for consideration in this dispute.

Amount in Dispute: $29,908.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The inpatient hospital services which are the subject of this dispute were reimbursed pursuant to the terms of a preferred provider or managed care contract in effect at the time the services were rendered. Attached as **Exhibit 1** is a copy of a printout of the terms of the contract, retrieved from the computer database to the carrier's audit company."

Response Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 25, 1996 to October 8, 1996	Inpatient Hospital Services	$29,908.22	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the applicable procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in this dispute.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on October 3, 1997.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F- Reduction according to Fee Guidelines.

Issues

1. Did the requestor make a timely request for medical fee dispute resolution?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the proper rule to address fee payment issues in this dispute?
4. Did the requestor submit the request in the form and manner required by Division rule?
5. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a), effective June 3, 1991, 16 *Texas Register* 2830, requires that "A request for review of medical services and dispute resolution, as described in the Texas Workers' Compensation Act (the Act), §8.26, shall be submitted to the commission at the division of medical review in Austin, no later than one calendar year after the date(s) of service in dispute." The applicability of the one-year filing deadline from the date(s) of service in dispute was confirmed in the court's opinion in Hospitals and Hospital Systems v. Continental Casualty Company, 109 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). Per 28 Texas Administrative Code §102.3(a)(1), effective January 1, 1991, 15 *Texas Register* 6747, "In counting a period of time measured by days, the first day is excluded and the last day is included." The request for dispute resolution of services rendered on dates of service September 25, 1996 through October 8, 1996 was received by the Division on October 3, 1997. Review of the submitted documentation finds that the request was submitted more than one year after the date of service. The Division finds that the request for dispute resolution was not submitted timely. The Division concludes that requestor has not met the requirements of §133.305(a). Therefore, service dates September 25, 1996 through October 2, 1996 will not be considered in this review. However, the request for dispute resolution of services rendered on October 3, 1996 through October 8, 1996 were submitted in accordance with the timely filing requirements of §133.305(a); therefore, these services will be considered in this review.
2. The insurance carrier reduced or denied disputed services with reason code F– "Reduction according to Fee Guidelines." However, the respondent's position statement dated September 15, 1998 contends that "The inpatient hospital services which are the subject of this dispute were reimbursed pursuant to the terms of a preferred provider or managed care contract in effect at the time the services were rendered." No documentation was found to support that the disputed services were reimbursed pursuant to the terms of a preferred provider or managed care contract in effect at the time the services were rendered. Review of the submitted information found no documentation to support that the disputed services were subject to a contractual agreement between the parties to this dispute. The respondent did not submit a copy of the alleged contract(s) for review. No documentation was found to support that the insurance carrier (British American Insurance Company) had been granted access to the health care provider's contractual fee arrangement with the alleged preferred provider or managed care network. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
3. This dispute relates to inpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guidelin*e at 28 Texas Administrative Code §134.400, 17 *TexReg* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."

   The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."

4. 28 Texas Administrative Code §133.305(d)(10), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "a summary of the requesting party's position regarding the dispute." Review of the documentation submitted by the requestor finds that the request does not include a summary of the requesting party's position regarding the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(10).
5. Review of the submitted documentation finds that:
   - The requestor did not submit a position statement for consideration in this dispute.
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
   - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

After thorough review and consideration of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305. The requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	October 24, 2014
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	October 24, 2014
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.